Together for Quality (TFQ) RFP

Vendor Conference Follow-Up Questions

Alabama Medicaid Agency

Posted 7/19/07

1. Please provide more detail on what you mean by 'open systems technology', e.g. Do you mean Open Source Technology, licensed under an Open Source License, e.g. BSD type license, or do you mean conformant to openly available system technology standards, such as those already listed? **Open source and open standards are frequently confused. Open source is a type of software defined by its collaborative development, accessibility of code and distribution model. Thousands of software developers will collaborate in communities to share knowledge and create technology for the common good. This model has proven adept at driving competition, lowering prices, and forcing market leaders to innovate, clone, or find new businesses.**

Open standards are the "beams and mortar" that allow different systems, platforms, and devices to communicate, and are at the very core of the new "open" architectures. Like open source, open standards result from a collaborative process where no one individual or entity controls the standard, and are available to all generally free of cost with no royalty or fee. The Internet, based largely on the framework of the TCP/IP and HTML standards, is a strong example of open standards-driven innovation. ODF is an example of an open standard. ODF is an XML-based document file format for displaying, storing and editing office documents, such as spreadsheets, charts, and presentations.

Vendors may create either open source or proprietary software conforming to an open standard. Open standards provide choice and interoperability between systems.

2. Many EMR systems do not support the listed interoperability profiles or support the HIE exchange standards which you have listed. Do we need to include in our plan and cost proposal our approach and price to developing interfaces and integrating unique interfaces to an assumed number of these systems? **Refer to Vendor Pre-Conference Question #179.**

3. Please confirm that a state Common Client Index or Enterprise Master Patient Index does not exist as yet? If not, in the process of implementing one, do we need to include in our plan and cost proposal our approach and price to developing interfaces and integrating unique interfaces to an assumed number of source systems including the state systems such as AIMS, EPI etc. **There is not a current client index. Your proposal should include all costs that may be associated with the establishment of the CCI.**

4. Some of the existing State solution technologies listed in the RFP to not conform to the HIE exchange standards listed. Should we propose a HIE consistent with HIE standards and assume that the State solution technology partners will also migrate to the HIE standards within the time frame of the project? **No.** Or do we need to include in our plan and cost proposal our approach and price to developing interfaces from the HIE to the existing state solution technologies listed in the RFP that do not conform to the HIE exchange standards list? **Yes.**

5. In other Jurisdictions, a single set of Jurisdictional HIE standards were specified and made mandatory by the Jurisdiction to limit the significant cost for integration, normalization, translation and transformation. In other words, only those EMR solutions conformant to the Jurisdictional HIE standards were eligible to participate. Is this an approach that the State is prepared to follow when developing interfaces as necessary for connectivity between all 500 providers and the pilot ECST? **Refer to Vendor Pre-Conference Question #179.**

6. In other Jurisdictions, enabling consumer access to information available through the HIE is an important consideration when developing the HIE architecture. Are some selected consumers to be included in the list of 500 pilot sites? **No**, **the 500 pilot sites will be providers, not consumers.**

7. Federal/State legislation provides support for Provider and Consumer Consent Directives for provider and system access to information. Do we need to include in our plan and cost proposal our approach and price to developing interfaces and federating consumer consent directives? **Yes, the Vendor must be able to allow consumer opt-out.** Do we need to include in our plan and cost proposal our approach and price to developing interfaces and federating provider consent directives? **Yes, if this concerns the consumers ability to define the level of access a provider has.**

8. The state already has a provider identity management and a provider access management framework that governs end user credentials, rights and privileges. Can we leverage the provider/practitioner data defined in this repository in our proposed solution for the initial pilot of 500 Medicaid provider systems? ***The existing framework is specific to State employees not providers.***

9. If not, does the state already have an electronic registry of providers/practitioners that we can leverage to identify providers? ***This information will be made available at the conclusion of the State's survey to identify the pilot sites.***

10. Will the state continue to use their existing identity and access management infrastructure to configure and specify provider identity, access management, roles and delegations to the solution and system software implemented in this proposal? ***The existing framework is specific to State employees not providers.***

11. V. HHS Interoperability: The RFP references the ADSS AIMS database.
a) Was this system developed specifically for ADSS or is it a COTS or COTS-like product? **The system was developed specifically for ADSS.**
b) Can you provide a more detailed description of the functionality of the system, the language in which It is written, what types of staff have input and retrieval authorization? **The E&D Waiver portion of AIMS tracks clients, the services they received, and sends claims data to EDS. The data is stored in an SQL database. AIMS has two versions for data entry. One is written in VB6 and the second in VB.Net. Area Agency on Aging case managers and ADSS E&D Waiver staff have access.**
c) Can you provide a copy of the forms, database construction and/or output of AIMS as it relates to the information which you want to make available through the TFQ initiative? **The database information is included as Attachment Two to the Vendor Pre-Conference Questions. Attachment One to this document contains additional information as it relates to additional data elements required through this RFP.**
d) Please describe the evaluative tools, if any, related to these forms and activities which are incorporated in the database. If there are none, is this data base used primarily to store information in one place? **There are no evaluation tools. The database will be used primarily to store information.**

12. V. HHS Interoperability: a) Is Adult Day Health Care provider approval and re-approval data currently stored and/or maintained electronically? **No.**
b) If not, how it is collected and maintained and what types of staff are responsible for so doing? **Data is currently collected and maintained manually by Medicaid and ADSS staff.**
c) If yes, can you provide a description of the data base in which it is maintained? ***N/A***
d) Is it the intent of this RFP to have a vendor develop and maintain such an electronic format if the data is not currently maintained electronically? **Yes.** If so, is it the intent of this RFP to have the vendor incorporate decision-making features related to approval/re-approval into any electronic development or maintenance of this file or only to incorporate alerts to state staff concerning status changes? **Alerts and messaging only.**
e) Can ALMA provide vendors with a list of reports associated with this system? **Yes, refer to Attachment Two of this document.**
13. V. HHS Interoperability: a) Are the requirements in sections 6-9 related only to Adult Day Health Care providers or to all providers participating in the HCBS waiver? **It applies to all providers participating in the HCBS waiver.**
b) If more than ADHC providers are included, are the corrective action plan and alert processes the same and performed by the same types of staff, regardless of provider/program type? **Yes**

14. V. HHS Interoperability: a) Is it the intent of the RFP to have the vendor incorporate the capability of electronically identifying the substantive issue (s) needing corrective action and then forwarding the overall request for a CAP to ADSS, or is it only to incorporate the capability of forwarding the request to ADSS? **To incorporate the capability of forwarding the request to ADSS.**
b) Similarly, is it the intent of the RFP to have the vendor incorporate the ability to electronically determine the appropriate response(s) between ADSS and ALMA or only be able to forward such requests and responses back and forth between the agencies? **To forward such requests and responses back and forth between the agencies.**
c) Is it the State's intent for the system to track dates associated with CAPS? **Yes**

15. V. HHS Interoperability: Is it the intent of the RFP to have the vendor incorporate the specific indicator reports in the TFQ system or rather to be able to access these reports through the TFQ system but have them maintained on an existing ALMA or ADSS system? **The intent is to have the vendor incorporate the specific indicator reports into the TFQ system. The State does not have a preference where the information resides as long as the information can be integrated into the solution.**

16. V. HHS Interoperability: a) What agencies currently provide the specific types of information noted in this paragraph? **ALMA and ADSS.**
b) How do they currently transmit this information to ADSS and/o ALMA? **Hard-copy forms.**
c) If the data is not currently provided through some sort of electronic feed, is it the intent of this RFP to include that development work at this time? **Yes**

17. Question #50: In the answer to question #50 which relates to providers participating in the pilot you state the following: "The Agency will develop the agreement and begin the process of having providers sign the agreement, but it will the Vendor's responsibility to ensure that all agreements are in place at time of implementation/training." The answer to question #105 states that "It [responsibility for obtaining sharing agreements from providers] will be the vendor's responsibility. It appears that there are two separate agreements: one for the 500+ providers that are participating in the pilot and one for all providers who are allowing their medical records data to be accessed.

a) Please confirm whether there are two separate agreements and whether our understanding of the providers involved in both are correct?
Yes there are two separate agreements and providers are involved in both. One agreement will be between Medicaid and the provider and the other agreement will be between the RFP awarded vendor and the provider.

b) Does the State expect, in either case, that the vendor will be responsible for obtaining these agreements, even if the State has started the process of obtaining signed agreements?
Yes, the RFP awarded vendor will be responsible for ensuring that both agreements are in place.

18. F. Data Integration Solutions: In order to plan for the interoperability pilot, vendors need to understand the number of providers and locations of the users associated with each practice management system listed on page 35.

a) As the State is responsible for hardware and software procurement, will the State be responsible setting up any required peripheral hardware establishing connectivity within the allotted pilot timeframes?
Refer to Vendor Pre-Conference Question #179.

b) Will the State be responsible for negotiating the connectivity schedules with each EMR vendor and location?
Refer to Vendor Pre-Conference Question #179.

19. W. Copies Required: The State requires one electronic copy of the proposal on CD in Word format.
a)For documents that must be signed, may the Vendor scan the signed documents and provide a PDF file instead of a Word file? **The electronic copy does not have to contain signed documents.**
b)May the Vendor provide a PDF file of the implementation project plan schedule? ***Yes.***

20. Page 15, item 8 mentions that the notification engine could handle changes in eligibility and forward to all the necessary parties. Is it anticipated that eligibility changes would be posted to the EMPI/RLS as they occur? **No. This was just an example. Eligibility verification is not a required component of the RFP.**

21. Will the State provide a network diagram of the active directory forest, to include where there is network segmentation? A **description of the location of domain controllers that are on different subnets in an effort to avoid any firewall issues is Attachment Three.**

22. Is the State completely connected or are there remote nodes? **The State is completely connected.**

23. Does the State have a preference between Security Assertion Markup Language (SAML) and WS-Federation? **Answer not available at time of posting.**

24. Does the State currently use active directory federation services (ADFS)? **No.**

25. What release of active directory (AD) is currently installed? **Windows 2003.**

26. Does the State have a consolidated ID management store or, do users have different identities in every application? **There is no one meta database with all user identifications that ALL applications use. However, there is a very large AD environment that many, and in some Agency cases all, applications use.**

27. Has the State written their own provisioning system or is it a COTS provisioning system? **No**. Will the State please provide the details of this solution? **The State uses no auto provisioning software.**

28. What methods of authentication does the State currently use (for example, password, 2 factor, certificate based)? **Password.** Does the State intend to keep this method or change to another for this RFP? **Intend to keep this method.** What method of authentication does the State prefer? **Minimum standard but applications and enhance authentication methods.**

29. Original question # 149: Will the State please provide an answer to the question. What are the application and network architecture for the following clinical databases that will need to be accessed by ALAHIS: **Refer to the Pre-Vendor Conference Question #149.**

Immunization data	
Demographic, Claims and Lab Data	
On-Line Disaster Network	
Emergency Patient Information	
AIMS	
Pharmacy Prior Authorization	

30. Original question # 148: Will the State please further expand on the process and/or procedures for presenting new information and interface requests to the TFQ Stakeholder Council and Steering Committee and how any new work might be costed and appended into this project's schedule. The time period covering this project is short and aggressive. **Changes to the scope of work contained in this RFP are not anticipated unless there has been a critical oversight. However, as stated in the original answer any changes would be presented and governed by the TFQ Stakeholder Council through the established Steering Committee and would be predicated on the per hour costs provided in the RFP response.**

31. Regarding pilot participation, when does the State anticipate completing the identification and recruitment of the 500 physician pilot participants?

This will be done prior to the award of the contract.

32. What are the rough timelines for bringing non-Medicaid providers into the EHR and ECST? **This is not a requirement of this RFP.**

33. HIE applications and solutions across the industry are in the early stages of product evolution. The RFP seems to anticipate vendors developing, installing and then briefly supporting an HIE solution. Will ALMA entertain an Application Services Provider based model in which the vendor hosts and supports the solution as a fee for service? **No.**

34. Many respondents will propose HIE solutions and products already in use in other states. While these products may be modified or configured to meet ALMA's specific needs, they will likely not be built from scratch, especially in the given timeframe. Does section MM (Ownership) of the T&Cs intend for the vendor to transfer ownership of vendor's existing application to AL? **It is not the intent of the RFP to preclude a vendor from selling a solution that it develops to another entity. Section XV. MM. of the RFP will be amended to more accurately state the rights of the State and Federal government.**

35. To what extent, if any, does AL intend to claim ownership to modifications to vendor's existing application in the event such modifications are under development prior to the RFP award? **Refer to Question #34.**

36. If AL claims ownership to an existing application, how does AL intend to address specific components of an application that are merely licensed by the vendor who contracts with Alabama Medicaid? **Refer to Question #34.**

37. Section MM (Ownership) refers to 45 CFR 95.617 (a,b), but the language deviates from the specific requirements of section a (e.g. license versus ownership). To what extent, if any, does AL intend to incorporate the specific ownership requirements contained in the CFR? **Refer to Question #34.**

38. The CFR referenced in section MM has language requiring transfer of ownership for software that is designed, developed or installed by a vendor using federal funds. Does AL intend to apply that requirement to solutions that have been designed, developed and implemented in other markets that do not require "installation" on AL network? **Refer to Question #34.**

39. The RFP lists nine EMR and PMS systems to which the vendor must provide seamless integration. During the bidder's conference, it was explained that ALMA's expectation was that vendors must publish industry standard technical specifications allowing EMR/EHR vendors to interface with the HIE solution. Can you please confirm this clarification – will the owners/developers of those systems be responsible for providing the interface with the HIE solution? **Refer to Vendor Pre-Conference Question #179.**

40. Many clarifications were provided in the written answers to the questions submitted. Does information contained in written responses to questions take precedence over the RFP when there are discrepancies? **It is not the intent to create discrepancies between the RFP and the answers given, merely to clarify the RFP. Any changes to RFP requirements will be done via amendment.**

41. Many questions have been posed regarding the State's perceived strong preference for a purely Federated data model, which is in opposition with many required functions and the verbally stated requirement for speed and non-disruption of provider workflow. Attributes such as terminology mediation, business intelligence, profiling, decision support, quality analysis, and quick response times are normally associated with a hybrid or consolidated data model. Can you please elaborate beyond your prior written responses of "Vendor should propose the solution they perceive best meets the objectives stated in the RFP", where the boundaries lie in regards to an acceptable data model? **No.**

42. Can ALMA clarify in writing as part of this contractual RFP how many and what type of FTE's will be available from facilities in which source systems are required to feed ALAHIS? **State subject matter experts will be available to represent the State systems being interfaced. Resources from the source repositories have also been committed. There is not a set number of FTEs.**

43. In the written answer to question 78, ALMA has stated that $2.2M is available in each grant year and that these funds must account for the entire solution. The TFQ grant submission outlines (on page 13 and 14) $2.02M each year for the development of the HIE solution and various other funds for ECST enhancement and Web interfaces. Assuming the vendor can provide these services, are these funds in available addition to the $2.02M (or $2.2M) for development of the solution? **The vendor should not assume that additional monies would be available. There are numerous grant activities and the solution is but one of them.**

44. Can vendor make the assumption that if they provide everything to ALMA as a Service with the exception of $140K of the ALMA project manager, $10K in ALMA supplies, and $15K in Other Costs, that year 2007 vendor allocation would be $ 3,720,000 as opposed to the $2,020,000 stated in the RFP? **No.** Likewise if ALMA project manager, supplies, and other costs are taken out of 2008 and vendor supplies everything else as a service is it assumed that $ 3,473,000 would be available in 2008? **No.** Intent of the question is to fit ALMA desired functionality into feasible business model.

Budget Year	2007	2008
Personnel/Fringe Benefits	$140,000	$204,000
Contractual Costs	$3,320,000	$3,373,000
Supplies	$10,000	$10,000
Equipment	$400,000	$100,000
Other Costs	$15,000	$15,000
TOTAL	$3,885,000	$3,702,000

45. It appears in the TFQ Grant that ALMA will provide the following…."Equally significant to acceptance and use of the system developed is technical support, publicity and education. Salaries for five contracted provider support staff ($99,000 each per year) are included as contract costs. Support staff will conduct focus groups to seek input on the functionality of the PDH, recruit physicians to use the PDH to its fullest, and support enrolled physicians as they deal with new technologies." Please clarify this with RFP Questions & Responses where ALMA indicated that vendor would be responsible recruiting physicians to use the PDH to its fullest, and support enrolled physicians as they deal with new technologies. **The State envisions that the pilot areas will be identified and that the agreement process will begin. The Vendor; however, will have the responsibility for ensuring that the agreements are in place and will work with the pilot providers for solution implementation and support, including recruiting additional providers as may be necessary.**

46. Since the contract will not commence until at least 9/10/07 can the $2.02M per year be redistributed to a lower 07 amount and a higher 08 amount? Likewise, is it assumed that the 09 calendar year will be funded by a separate source outside of the Transformation Grant since the grant implies the grant period ends 12/31/08? **Yes, the State is not locked into grant years for expenditures.**

47. Is it possible that ALMA will focus the pilot to a defined region or two in order to obtain the necessary care coordination among primary care, specialties, pharmacies, facilities, rural, suburban, urban etc. in order to better assess the overall impact of the intervention in the short time frame allocated by the grant? (The assumption being that the solution would certainly work for the entire state, but the pilot being a focused effort to illustrate quality improvement). **Yes, the State will focus the pilot into no more than 15 counties scattered throughout the State. It is not known at this time the number of providers within each county, but it will be less than the original 500 stated.**

48. During the bidder's conference we understood that the requirement for "predictive modeling" actually relates to a severity stratification tool for care managers following just diabetes and asthma to start, with the potential for adding obesity, COPD, Stroke and CAD. Is this correct? **Yes.**

49. The USPSTF guidelines are referenced for "flags", but it was mentioned that ALMA/TQF does not anticipate that all guidelines would be required. Is this correct? If so, does ALMA/TQF have a priority list of the most desired USPTF guidelines it can send to vendors? **No. The Vendor should make recommendations concerning a priority listing.**

50. July 13's meeting left us with the impression that ALMA will bear the responsibility for obtaining participation agreements with providers. Is this correct?

Will this agreement include sharing provider clinical data with the network? **Please refer to Questions #17 and #45 of this document.**

51. The "link" to pharmacy PA means accessing the current HID web based application, which is anticipated to provide near real-time responses. Is this correct? What further communication to the ECST is desired? **Please refer to Vendor Conference question #19. The responses are not expected to be real-time.**

52. The solution must encompass communications between the ALMA care managers and providers. Is this correct? **Yes.**

53. Appendix "D" lists data elements, and ALMA/TQF indicated that any element characterized as "provider entered" is "optional". Is this correct? **Optional to be entered; however, the solution must be able to support the data.**

54. It was stated that the system must communicate with providers without connectivity via a fax-back function. Is this correct? **Yes.**

55. Much of the required data resides with BlueCross BlueShield of Alabama within InfoSolutions and EPI. Success for this pilot will rely upon ready access to BCBS of Alabama IT support staff in order to establish connectivity to this data in the time allotted. Does BCBS have staff dedicated and available for this level of collaboration beginning immediately after award of this RFP? **All source systems are committed to this project.**

56. Can you please clarify your intent in the pricing requirements where percentages of the total cost for individual deliverables cannot exceed a certain number? As it is currently structured, percentage points under in one area cannot be allocated to another. In order to add to 100%, vendors would have to propose the maximum percentage allowed for each deliverable. We need some leeway in order to price by deliverable. For example, it is likely that the development of the ECST tool (G) will be more than twice as costly as the submission of the project plan (C). **Please refer to the revised Pricing Schedule One contained in the RFP amendment.**

ATTACHMENTS
One – Question 11.C – Additional Data Elements
Two – Question 12.e. – Reports/Outputs
Three – Question 21 – Domain Controller Diagram

Attachment One to Vendor Conference Follow-up

List of additional data elements that ALMA would like to see included in the AIMS database.

Element	***Comments***
HCBS Waiver Operating Agency Name	For provider identification
HCBS Waiver Direct Service Provider List	For provider identification
HCBS Waiver Case Manager Name	For contact purposes
HCBS Waiver Service Authorization Form	To identify services authorized
HCBS Medication List Form	Documents current prescribed medications
HCBS Adult Day Health Approval Form	Compliance reviews
ADSS Claim Submission Data	Billing record reviews
Complaint and Grievance Log	Reporting and tracking complaints and grievances
Corrective Action Plan Form	Audit results
Audit alert notification	Audit dates
Medicaid Indicator reports	Performance Measurement Reporting
Criminal history alerts	Provider enrollment
ECST	Case management

Attachment Two to Vendor Conference Follow-Up

Letters/ Forms/Purposes/ Descriptions/Output and Additional Data Elements

Approval Letter for the Plan of Correction

Purpose: The purpose of this document if to generate an approval or disapproval of the plans of corrections. This document is used on a daily basis. It is generated to the operating agency and LTC Programs by Q/A.

Description: The document should contain the following elements and an example is listed below; date, to whom the document is generated to, the approval or disapproval statement, comment section, contact information and from whom the document is from.

Format:

July 6, 2007

LaGretta Ratliff, Community Service Director
Region I Mental Retardation Community Services
4104 Highway 31 South
Decatur, Alabama 35603

Dear Ms. Ratliff:

Your plan of correction dated June 26, 2007; addressing findings from your desk audit conducted on April 30, 2007, has been received and approved. If you have questions, you may contact me at (334) 353-4599.

Approval Letter for the Adult Day Health Centers

Purpose: The purpose of this document if to grant an initial or annual approval for the ADH. This document needs to be generated to the operating agency and LTC Programs by Q/A.

Description: The document should contain the following elements and an example is listed below; date, to whom the document is generated to, the approval or disapproval statement, comment section, contact information, the ability to choose an annual of initial options and from whom the document is from.

Format:

Ms Sue Acreman
Crenshaw County Adult Day Care
P. O. Box 19
Luverne, Alabama 36049

Dear Ms Acreman:

Medicaid has received a report from the Alabama Department of Senior Services indicating your facility maintains compliance with administrative policies and procedures, record keeping and billing documentation. The facility review conducted by this office in November 2005 indicates your facility maintains compliance with the facility requirements.

Since all the requirements of the Medicaid Adult Day Health Standards has been met, the facility is approved as a Medicaid Waiver provider for FY-2006. Your next facility review will be conducted in FY-2007; you will be notified in advance of the review date.

If you have questions or need additional information, feel free to contact me at (334) 242-1705.

Complaints and Grievances Log

Purpose: The purpose of this document if to contain all complaints and grievances received in a specified quarter. This document is generated from the operating agency to Q/A and LTC Programs.

Description: The document should contain the following elements and an example is listed below; client's name and Medicaid number date of the complaint, nature of complaints/grievances, disposition of the complaints/grievances, date resolved, name of person completing the form and the date generated.

Format:

Name and Medicaid Number	Date of Complaint	Nature of Complaint/Grievance	Disposition of Complaint/Grievance

Annual Quality Indicator Report

Purpose: The purpose of this document is to generate quality indicator measures and information gathered in a specified year.

Description: The document should contain the following elements as listed in the attached format.

Format:
Please see Attachment Two.A.

Quarterly Quality Indicator Report

Purpose: The purpose of this document is to generate quality indicator measures and information gathered in a specified quarter.

Description: The document should contain the following elements as listed in the attached format.

Format:
Please see Attachment Two.B.